

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
06984
1
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or Print)	First	Middle	Lost	20. DATE KNOWN OF ESTI. DEATH MADE	Month	Day	Year	2b. HOUR			
Dow	Windsor	Bailey		5-1-1968				8:30			
3. SEX	4. RACE	S. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.						
Male	White	02-03-94	74 yrs.	MONTHS	DAYS	HOURS	MIN.				
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	9. COUNTY OF DEATH								
Md.	PA-4 USA	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Dorchester								
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY								
Rural-Cambridge	Eastern Shore State Hosp	Farmer	Farm								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER							
Maryland	Wicomico	Mardela	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	Main St.							
14. FATHER'S NAME	First	Middle	Lost	15. MOTHER'S MAIDEN NAME	First	Middle	Lost				
Marcellus		Bailey		Annie			Jones				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16b. SOCIAL SECURITY NO. (If yes give war or dates of service)	17. INFORMANT ADDRESS									
yes	World War I 219-07-7618A	Med. Records Eastern Shore State Hospital									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	MRS. Mamie L. Bailey (wife) Mardela, Md.										
887X	Terminal & neumonia										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.	Due to, or as a consequence of										
(b)	Fracture neck l. femur										
(c)	3 mo.										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
9040											
19a. DATE OF OPERATION 1/11/68		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 2/2/1968		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Fell in home							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
						Mardela		Wicomico		Md.	
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>John Mace Jr.</i>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>							
EXAMINER'S NAME (Type) JOHN MACE JR.				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>							
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
				ADDRESS (Street, city, town, or county)							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE May 9, 1968		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Mardela Memorial Cemetery		23d. LOCATION (City or Town) Mardela, Wicomico, Maryland		(County)		(State)	
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND				25a. REC'D BY REGISTRAR DATE MAY 9 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					
VR A15ME (5) 1DM REV. 1/68											

48220

FOR STATE
HEALTH DEPT.

1
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give badges 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

2
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item # 2a. Film G401 MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06990

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06996

1. DECEASED NAME (Type or Print)		First Rosie	Middle Keene	Last Brown	20. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 5/13/68 19 M	2b. HOUR M					
3. SEX Female	4. RACE Negro	S. DATE OF BIRTH 1/1/1930	6. AGE (In years last birthday) 38 YRS.	IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS DAYS 0	MIN. 0	2d. HOUR M				
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Dorchester	10. CITY OR TOWN OF DEATH Cambridge	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Cambridge Md. Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Laborer	12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Dor.		13c. CITY OR TOWN Cambridge	13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER R.F.D. 2	14. FATHER'S NAME First Steven	Middle Thomas	15. MOTHER'S MAIDEN NAME First Virginia	Middle Palmer	Lost
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Russell Brown Jr. RFD 2 Cambridge, Md.		ADDRESS APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1hr.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o) 4201											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town	County	State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>John Mace Jr.</i>		EXAMINER'S NAME (Type) John Mace Jr. M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		MD.	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	22b. DATE SIGNED 5/14/68			
23a. BURIAL/CREMATION, REMOVAL (Specify) Burial		23b. DATE 5/19/68		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Lane's Cemetery		23d. LOCATION (City or Town) (County) (State) Taylor's Island, Dor., Md.					
24. FUNERAL DIRECTOR St. Clair Funeral				25a. REC'D BY REGISTRAR DATE M.M. 23 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					

0200

Lands End

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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06991

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06997

1. DECEASED-NAME (Type or print)	First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR AM/PM
ANNA CLARA CAREY			CAREY	May 24 1968	6:30 P.M.
3. SEX	4. RACE	S. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
Female	white	11-06-10	57 yrs.		
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED NEVER MARRIED WIDOWED DIVORCED	9. COUNTY OF DEATH	Md.	
PENN.	U.S.A.		Dorchester		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY		
Rural-Cambridge	Eastern Shore State Hospt. Housewife				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER	
MD.	Talbot	Easton	YES <input checked="" type="checkbox"/>	107 Sycamore Ave.	
14. FATHER'S NAME	First	Middle	Last	15. MOTHER'S MAIDEN NAME	First
Ludwig		Rouchut		Hannah	Frey Rouchut
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	16b. SOCIAL SECURITY NO.	17. INFORMANT	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
UNKNOWN	Provider # 31-4002	Medical Records Address Eastern Shore State Hospital	2 days.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vasculitis Coagulant</u>					
4120 DUE TO, OR AS A CONSEQUENCE OF					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hyperkinetic Cardiovascular Disease</u>					
2 yrs.					
DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
443) <u>Chronic Brain Syndrome Ass. w Central Disturbance</u>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
MEDICAL CERTIFICATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>5-10</u> , 19 <u>67</u> , to <u>5-24</u> , 19 <u>68</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>5-24</u> , 19 <u>68</u> , and that in <input checked="" type="checkbox"/> (my) <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) <input checked="" type="checkbox"/> (did) <input checked="" type="checkbox"/> (did not) view the body after death.					
22b. SIGNATURE <u>Miguel A. de la Guardia MD</u>	DEGREE ATTENDING PHYS.	<input type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED <u>5/24/68</u>	
22d. PHYSICIAN'S NAME (Type) <u>Miguel A. de la Guardia</u>	22e. ADDRESS <u>E. S. S. H.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE 5/27/68	23c. NAME OF CEMETERY OR CREMATORIAL St Michaels Meth. Cem.	23d. LOCATION (City or Town) St Michaels, Talbot, Md.	(County)	(State)
24. FUNERAL DIRECTOR <u>Jay W. Heverin</u>	ADDRESS <u>Easton Md.</u>	25a. REC'D BY REGISTRAR DATE MAY 28 1968	25b. REGISTRAR'S SIGNATURE <u>Charles Juge</u>		
VR A15 (4) 30M REV. 1/68					

2020

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06998

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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1. DECEASED-NAME (Type or print)				First Edward	Middle Averil	Last Dickerson	2a. DATE OF DEATH Month May	Day 29	Year 1968	2b. HOUR 6 A M				
3. SEX		4. RACE		S. DATE OF BIRTH			6. AGE (In years (at birthday) 56) YRS.		IF UNDER 1 YEAR MONTHS 0		IF UNDER 24 HRS. DAYS 0			
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Dorchester								
10. CITY OR TOWN OF DEATH Cambridge			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Cambridge-Md. Hospital				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Brick Layer			12b. KIND OF BUSINESS OR INDUSTRY Construct'n				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Dorchester		13c. CITY OR TOWN Cambridge		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1101 Roslyn Ave.						
14. FATHER'S NAME First Thomas				Middle Dickerson		Lost		15. MOTHER'S MAIDEN NAME First Emma		Middle		Lost White		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address Mrs. Edward Dickerson Cambridge Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Infarction APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr 493 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Bronchial asthma yes														
DUE TO, OR AS A CONSEQUENCE OF (c)														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 241 X <i>Rt lobectomy due to Emphysema yrs ago</i>														
19a. DATE OF OPERATION 241 X		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> on work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No.		City or Town		County	State			
22a. I certify that (I) (this hospital) attended the deceased from 3-10 , 19 64 , to 5-29- , 19 68 , that (I) (we) last saw the deceased alive on 5-29 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE <i>W. Baumann</i>														
22c. DATE SIGNED 5-31-68														
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS										
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5/31/68		23c. NAME OF CEMETERY OR CREMATORIAL Dorchester Mem. Park			23d. LOCATION (City or Town) Cambridge Dorchester Md.		(County)		(State)			
24. FUNERAL DIRECTOR <i>Reynolds & Thomas Jr.</i>				ADDRESS Cambridge Md. 21613			25a. REC'D BY REGISTRAR DATE JUN 3 1968		25b. REGISTRAR'S SIGNATURE <i>Charles J. Jones</i>					

42200

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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1. DECEASED-NAME (Type or print)		First	Middle	Lost	2a. DATE OF DEATH 5-25-68	Month	Day	Year	2b. HOUR 8 P M			
Edward Leo Ege, Sr.					5	-	-	-				
3. SEX	4. RACE	5. DATE OF BIRTH 3-30-1883			6. AGE (In years last birthday) 89		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			
Male	Cau.				YRS.							
7b. BIRTHPLACE (State or foreign country) Pennsylvania	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Dorchester							
10. CITY OR TOWN OF DEATH Hurlock	11. NAME OF HOSPITAL OR INSTITUTION Belle Haven Nursing	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Railroad Worker			12b. KIND OF BUSINESS OR INDUSTRY Railroad							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) Maryland	13b. COUNTY Caroline	13c. CITY OR TOWN Greensboro			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER None					
14. FATHER'S NAME John Ege	First	Middle	Last	15. MOTHER'S MAIDEN NAME Sarah Faust			Address Md. Greensboro					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? No	16b. SOCIAL SECURITY NO. 221-12-5339-A	17. INFORMANT Edward L. Ege, Jr.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 mos	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Cardiac Decompensation</u>												
4120 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypertensive arteriosclerotic Heart Disease</u>											7 yrs	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 4438 (c) <u>Generalized arteriosclerosis</u>											25 yrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Vascular Occlusion w/ Hypo. G.I. & Central Nervous System 13 yrs ag</u>												
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town			County			State		
22a. I certify that (I) (this hospital) attended the deceased from 7/27, 1967, to 5/25, 1968, that (I) (we) last saw the deceased alive on 5/24, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE Harold B. Rummel		110	DEGREE	ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED 5/26/68					
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS Portion Maryland										
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5-28-68	23c. NAME OF CEMETERY OR CREMATORIAL Silverbrook	23d. LOCATION (City or Town) Wilmington, Del.			(County)			(State)		
24. FUNERAL DIRECTOR John E. Bouland		ADDRESS Greensboro, Md.	25a. REC'D BY REGISTRAR MAY 28 1968			25b. REGISTRAR'S SIGNATURE Charles Judge						

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Revised edition
of the 1981
version

comes
from
the
same
source
as
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1981
version

and
is
an
expanded
edition

August 1988

100-007

100-007

100-007

100-007

FOR STATE
HEALTH DEPT.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED NAME (Type or Print)			First	Middle	Lost	20. DATE KNOWN <input type="checkbox"/> Month Day Year			2b. HOUR	
			Martha	Johnson	Ennalls	<input checked="" type="checkbox"/> DEATH MATED <input checked="" type="checkbox"/> 5/24 1968			? M	
3. SEX Female	4. RACE Negro	S. DATE OF BIRTH 5/11/1892	6. AGE (in years less birthday) 70 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.	2c. DATE PRONOUNCED DEAD Month 5 Doy 25 Year 1968			2d. HOUR 10AM	
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Dorchester				
10. CITY OR TOWN OF DEATH Crapo		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Laborer			12b. KIND OF BUSINESS OR INDUSTRY Factory		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13c. CITY OR TOWN Crapo		13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		13e. STREET AND NUMBER				
14. FATHER'S NAME First Frank			Middle Johnson	Lost	15. MOTHER'S MAIDEN NAME First Emma			Middle Travers	Lost	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 222-05-3090		17. INFORMANT Carroll Johnson Crapo, Md.			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ?
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> <u>4270</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) stating the underlying cause (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(o) <u>4341</u>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town	County	State	
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <i>John Mace Jr.</i>		EXAMINER'S NAME (Type) John Mace Jr. M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED 5/28/68		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 5/30/68	23c. NAME OF CEMETERY OR CREMATORIAL Bethel Cemetery			23d. LOCATION (City or Town) Cambridge, Dor.		(County) Md.	
24. FUNERAL DIRECTOR St. Clair Funeral			ADDRESS Cambridge, Md.			25a. REC'D BY REGISTRAR MAY 29 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

40200

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)	First MINNIE	Middle WILLEY	Last FAULKNER	2a. DATE OF DEATH Month May Day 9, 1968 Year	2b. HOUR M			
3. SEX Female	4. RACE White	5. DATE OF BIRTH Dec. 13, 1887		6. AGE (In years lost birthday) 91 00 YRS.	IF UNDER 1 YEAR MONTHS 9	IF UNDER 24 HRS DAYS 0	HOURS 0	MIN. 0
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED X DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Dorchester					
10. CITY OR TOWN OF DEATH Cambridge	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 323 Henry Street		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. COUNTY Dorchester	13c. CITY OR TOWN Cambridge	13d. INSIDE CITY LIMITS? YES X NO	13e. STREET AND NUMBER 323 Henry Street				
14. FATHER'S NAME First George	Middle W.	Last Willey	15. MOTHER'S MAIDEN NAME First Levina	Middle ?	Last Condon			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO. ---	17. INFORMANT LeCompte Funeral Service records	Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4319						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days		
DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerosis								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 331X								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from 12-11-50 , 19____, to 5-9-68 , 19____, that (I) (we) lost saw the deceased alive on 5-7-68 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <i>Albert E. Bunker, M.D.</i>		ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 5-10-68			
22d. PHYSICIAN'S NAME (Type) ALBERT E. BUNKER, M. D.		22e. ADDRESS 200 Md. Ave., Cambridge, Md. 21613						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE May 11, 1968	23c. NAME OF CEMETERY OR CREMATORIAL Belmont Cemetery	23d. LOCATION (City or Town) Choptank, Maryland		(County) (State)		
24. FUNERAL DIRECTOR LeCompte Funeral Service, Cambridge, Maryland		ADDRESS		25a. REC'D BY REGISTRAR DATE MAY 15 1968	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

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Journal of Health Politics, Policy and Law, Vol. 35, No. 3, June 2010
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2020-21 *2021-22* *2022-23* *2023-24* *2024-25*

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												7002	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH													
1. DECEASED NAME (Type or Print)			First	Middle	Last	2a. DATE KNOWN OF ESTI- DEATH MATED			Month	Day	Year	2b. HOUR	
Teresa Marienette Fisher						<input checked="" type="checkbox"/>			5-12	19	68	1A M	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)			IF UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD			2d. HOUR
Female	Negro	8/9/1948	19 YRS.			MONTHS	DAYS	HOURS	MIN.	Month	Day	Year	12:15 A.M.
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?			B. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Md.		USA							Dorchester				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY				
Cambridge			710 Washington St.			Student			School				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER					
Md.		Dor.		Cambridge		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		7 10 Washington St.					
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last		
James Carroll Fisher						Lillian Turpin							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT			ADDRESS						
No		220-52-2326		Lullin T. Waters			Cambridge, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
421.2 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) last.												Instant	
Etiology unknown DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o) 4330													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?							
						<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <i>John Mace Jr.</i>		EXAMINER'S NAME (Type) John Mace Jr. M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county) Cambridge, Md.			22b. DATE SIGNED 5/14/68			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5/16/68		23c. NAME OF CEMETERY OR CREMATORIAL Waugh Cemetery			23d. LOCATION (City or Town) (County) (State) Cambridge, Dor. Md.						
24. FUNERAL DIRECTOR St. Clair Funeral		ADDRESS Cambridge, Md.		25a. REC'D BY REGISTRAR DATE MAY 23 1968			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>						

82220

P. Young

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

4		M		06997		07003					
1. DECEASED-NAME (Type or print)		First HATTIE		Middle		Lost FOXWELL		2a. DATE OF DEATH Month MAY Day 13 Year 1968		2b. HOUR 11:20 A.M.	
3. SEX FEMALE		4. RACE WHITE		S. DATE OF BIRTH 12/25/93		6. AGE (In years last birthday) 74 YRS.		IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS. HOURS 0 MIN. 0	
7a. BIRTHPLACE (State or foreign country) Mo.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH DORCHESTER					
10. CITY OR TOWN OF DEATH RURAL CAMBRIDGE		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) EASTERN SHORE STATE HOSP.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Mo.		13b. COUNTY Car.		13c. CITY OR TOWN DENTON		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
14. FATHER'S NAME First MILTON TRICE		Middle		Lost		15. MOTHER'S MAIDEN NAME First CARRIE WRIGHT		Middle Last			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown? No		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT HOSPITAL RECORDS		Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia, lobar				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 days.					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 5900		DUE TO, OR AS A CONSEQUENCE OF (b) Chronic pyelonephritis				1 year					
		DUE TO, OR AS A CONSEQUENCE OF (c) Senility.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
21a. DATE OF OPERATION 21b. CONDITION FOR WHICH OPERATION WAS PERFORMED 21c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21d. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)											
21e. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19											
21f. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)											
21g. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from June 28 , 19 65 , to May 13 , 19 68 , that (I) (we) last saw the deceased alive on May 13 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Carlos F. Barroso M.D. DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> DATE SIGNED 5/13/68											
22d. PHYSICIAN'S NAME (Type) CARLOS F. BARROSO M.D. ADDRESS Flurlock Md.											
23a. BURIAL, CREMATION, REMOVALS SPECIFIED BURIAL MAY 6, 1968 23b. DATE 23c. NAME OF CEMETERY OR CREMATORIAL CONCORD 23d. LOCATION (City or Town) CONCORD (County) COP. (State) MD.											
24. FUNERAL DIRECTOR ADDRESS Virgil Moore & Son Denton Md. 25a. REC'D BY REGISTRAR DATE MAY 20 1968 25b. REGISTRAR'S SIGNATURE Charles Judge											

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1940 NO 710815

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Items #7b, 13e, Film #G400 5/24/68km **CERTIFICATE OF DEATH**

17004

1. DECEASED-NAME (Type or print)	First	Middle	Last	2d. DATE OF DEATH Month May	2b. HOUR Day 10 Year 1968 2P M
Ernest	George	Gadsby			
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday) 89 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
Male	White	4/19/1879			
7a. BIRTHPLACE (State or foreign country) England	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Dorchester	Md.	
10. CITY OR TOWN OF DEATH Cambridge	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Cambridge-Md. Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Custodian	12b. KIND OF BUSINESS OR INDUSTRY Church		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER Route 16		
14. FATHER'S NAME Albert	First Henry	Middle Gadsby	15. MOTHER'S MAIDEN NAME Emily	Middle C.	Last Brown
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO.	17. INFORMANT Mrs. Robert Foxwell	Address Madison Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION, ACUTE</u> 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> stating the underlying cause (c) <u>GENERALIZED ARTERIOSCLEROSIS</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 45 MIN		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o) 4201					
19a. DATE OF OPERATION MEDICAL CERTIFICATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>5-3</u> , 19 <u>68</u> , to <u>5-10</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>5-10</u> 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Donald R. McWilliams, Jr.</u>	DEGREE MEDICAL DIRECTOR <input checked="" type="checkbox"/>	ATTENDING PHYS. <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <u>5-11-68</u>	
22d. PHYSICIAN'S NAME (Type) Donald R. McWilliams	22e. ADDRESS P.O. Box 248 East New Market, Md., 21631				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 5/11/68	23c. NAME OF CEMETERY OR CREMATORIAL Glen Haven Mem. Park	23d. LOCATION (City or Town) Glen Burnie	(County) AA	(State) Md.
24. FUNERAL DIRECTOR <u>Kenneth R. Thomas Jr.</u>	ADDRESS Cambridge Md.	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE		
VR A15 (4) 30M REV. 1/68					

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他生「三身淨土」，即「淨居人、淨居天、淨居佛」。

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. DECEASED-NAME (Type or print)				First	Middle	Last	2a. DATE OF DEATH Month	2b. HOUR Year		
<i>Samuel</i>						<i>Harris Jr.</i>	5	3 AM		
3. SEX	4. RACE	5. DATE OF BIRTH			6. AGE (in years lost birthday)		7.2 yrs			
<i>Male</i>	<i>Colored</i>	<i>5/16/68</i>			IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Dorchester</i>				
<i>Easton, Md.</i>		<i>U.S.A.</i>								
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
<i>Nurlock Md</i>		<i>Belle Haven Nursing Home</i>			<i>Farming</i>			<i>Farm work</i>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER				
<i>Cordova Md.</i>		<i>Talbot</i>		<i>Cordova</i>	NO	<i>R.F.D.</i>				
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last	
<i>Samuel</i>				<i>Harris, Sr.</i>	<i>Augusta</i>				<i>Harris</i>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown		16b. SOCIAL SECURITY NO.			17. INFORMANT		Address			
<i>No</i>		<i>217-36-16044</i>			<i>Claribel B. Plummer</i>		<i>Nurlock, Md.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Chronic Cardiac Decompensation</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>74 mos</i>										
4120 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <i>Hypertensive arteriosclerotic Heart Disease</i> 10 yrs										
stating the underlying cause (b) <i>Old cerebrovascular accident right side</i> 4 yrs										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
443x										
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION			19c. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
							YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>4/10/68</i> , 19_____, to <i>5/2/68</i> , 19_____, that (I) (we) lost saw the deceased alive on <i>5/27/68</i> , 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>Plummer</i>		M.D. DEGREE			ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <i>5/29/68</i>		
22d. PHYSICIAN'S NAME (Type)		<i>Harold B. Plummer M.D.</i>			22e. ADDRESS <i>P.O. Box #158 Preston Maryland Carroll</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>6/1/68</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Newtown Cem.</i>			23d. LOCATION (City or Town) <i>Cordova</i>		(County) <i>Carroll</i>	(State) <i>Md.</i>
24. FUNERAL DIRECTOR <i>George H. Dashwell Carlton Md.</i>		ADDRESS			25a. REC'D BY REGISTRAR <i>JUN 3 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judd</i>			

20200

2007

FOR STATE
HEALTH DEPT.



any delay is
necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to
the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page
5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of
Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

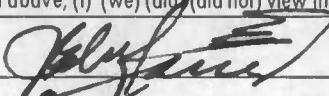
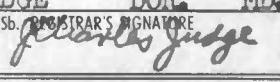
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												07006	
Items #2a, 10, 11, Film # MEDICAL EXAMINER'S CERTIFICATE OF DEATH													
1. DECEASED NAME (Type or Print)			First	Middle	Lost	20. DATE KNOWN OF ESTI- DEATH MATED			Month	Day	Year	2b. HOUR	
<i>Edwin Smith James Jr.</i>						<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	May	14	1968	M	
3. SEX		4. RACE	S. DATE OF BIRTH	5. AGE (in years last birthday)	6. IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.	2c. DATE PRONOUNCED DEAD			Month	Day	2d. HOUR	
<i>M.</i>		<i>White</i>	<i>5/19/1945</i>	<i>22 yrs.</i>			<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	19		M	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			<i>Dorchester</i>				
Md.		U. S. A.											
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY				
<i>Cambridge</i>			<i>Cambridge Md. Hosp.</i>			<i>Mechanic</i>							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. CITY OR TOWN COUNTY			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER				
<i>Md.</i>			<i>Dor.</i>			<i>East New Market</i>							
14. FATHER'S NAME			First	Middle	Lost	15. MOTHER'S MAIDEN NAME			First	Middle	Lost		
<i>Edwin Smith James Sr.</i>						<i>Ethel</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO. (If yes give war or dates of service)			17. INFORMANT			ADDRESS				
<i>9520</i>			<i>217-42-6198</i>			<i>Edwin James Sr.</i>			<i>East New Market</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carbon monoxide poisoning</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
												<i>Instant</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>9731</i>													
19a. MEDICAL CERTIFICATION			19b. DATE OF OPERATION			19c. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?				
									<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. 8 P.M. 5/14/1968			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.) <i>Ran hose from exhaust into auto</i>							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i>Highway</i>			21f. LOCATION Street or R.F.D. No. City or Town County State							
						<i>Near Secretary Dor. Md.</i>							
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <i>John Mace Jr.</i>						CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.			22b. DATE SIGNED <i>5/20/68</i>				
EXAMINER'S NAME (Type)						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county)							
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE <i>5/17/68</i>			23c. NAME OF CEMETERY OR CREMATORIUM <i>East New Market</i>			23d. LOCATION (City or Town) (County) (State) <i>East New Market, Dor. Md.</i>				
24. FUNERAL DIRECTOR			ADDRESS <i>Keith S. Holloway East New Market</i>			25a. REC'D. BY REGISTRAR DATE <i>MAY 22 1968</i>			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				

8005

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)				First	Middle	Lost	20. DATE OF DEATH	2b. HOUR	
ROBERT				LEE	JOHNSON		MAY 20, 1968	5:30 P.M.	
3. SEX	4. RACE	S. DATE OF BIRTH			6. AGE (In years lost birthday)	IF UNDER 1 YEAR		2b. HOUR	
MALE	NEGROID	JULY 12, 1934			33 YRS.	MONTHS	DAYS	IF UNDER 24 HRS.	
7b. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>			9. COUNTY OF DEATH				
MARYLAND	USA	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			DORCHESTER				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
CAMBRIDGE	CAMBRIDGE MD. HOSPITAL INC.			DECK HAND			WATERMAN		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER					
MARYLAND	DORCHESTER	CAMBRIDGE	YES <input checked="" type="checkbox"/>	606 BETHEL STREET					
14. FATHER'S NAME	First	Middle	Lost	15. MOTHER'S MAIDEN NAME	First	Middle	Last		
ANDREW				LEOTHIA			STUBBS		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> or unknown	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address						
NO	220-28-0673	LEOTHIA S. JOHNSON	CAMBRIDGE, MD.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorahagic pancreatitis</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5770									
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) last.									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o) 5870									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <u>5-15-68</u> , 19 <u>68</u> , to <u>5-20-68</u> 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>May 20, 1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE 		DEGREE	ATTENDING PHYS.	MED. DIRECTOR <input checked="" type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED May 21, 1968			
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS							
J. EDWIN FASSETT, M.D.		623 HIGH STREET CAMBRIDGE, MD.							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORIAL BETHEL			23d. LOCATION (City or Town)	(County)	(State)	
Burial		5/25/68				CAMBRIDGE	DOR.	MD.	
24. FUNERAL DIRECTOR		ADDRESS	25a. REC'D BY REGISTRAR MAY 29 1968			25b. REGISTRAR'S SIGNATURE 			
Frederick C. Al Clair		CAMBRIDGE, MD.							

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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07008

1		DECEASED NAME (Type or Print)	First ALBERT	Middle	Last KIRWAN	2a. DATE KNOWN OF ESTI- DEATH MATED	Month May	Day 22	Year 1968	2b. HOUR 7 PM
2		3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.			
		Male	White	Jan. 25, 1899	69 YRS.	MONTHS	DAYS	HOURS	MIN.	
3		7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8.	MARRIED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH	
		Maryland	USA	DOA	Cambridge Md. Hospital				Dorchester	
4		10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY					
		Cambridge	Cambridge Md. Hospital	Bus and Mail Route	Bus					
5		13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER				
		Maryland	Dorchester	Crapo	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	None				
6		14. FATHER'S NAME	First Benjamin F. Kirwan	Middle	Last	15. MOTHER'S MAIDEN NAME	First Mollie	Middle ?	Last Webster	
7		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16b. SOCIAL SECURITY NO. (If yes give war or dates of service)	17. INFORMANT	ADDRESS					
		No	217-30-9512	LeCompte Funeral Service records						
8		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:	IMMEDIATE CAUSE (a) Coronary occlusion DUE TO, OR AS A CONSEQUENCE OF				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 mins.			
		4109								
9		Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying cause</u> {	(b) _____ DUE TO, OR AS A CONSEQUENCE OF							
		last.	(c) _____							
10		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
11		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?		
								YES <input type="checkbox"/>	NO <input checked="" type="checkbox"/>	
12		21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)				
		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town	County	State
13		22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
		ACTUAL SIGNATURE <i>John Mace Jr. M.D.</i>								
14		EXAMINER'S NAME (Type) John. Mace Jr. M.D.								
15		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE May 25, 1968		23c. NAME OF CEMETERY OR CREMATORIAL Dorchester Memorial Park		23d. LOCATION (City or Town) Cambridge, Maryland		
16		24. FUNERAL DIRECTOR LeCompte Funeral Service, Cambridge, Maryland		ADDRESS		25a. REC'D BY REGISTRAR DATE MAY 27 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. DECEASED-NAME (Type or print)		First ERIC	Middle B.	Last LARSON	2a. DATE OF DEATH Month May Day 7 , Year 1968	2b. HOUR 11:15 A.M.		
3. SEX Male		4. RACE White	5. DATE OF BIRTH April 30, 1968		6. AGE (in years last birthday) — YRS.			
						IF UNDER 1 YEAR MONTHS 6	IF UNDER 24 HRS. DAYS 6	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Dorchester		
10. CITY OR TOWN OF DEATH Cambridge		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Cambridge Md. Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY — - -		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Dorchester		13c. CITY OR TOWN Cambridge		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME First Warren E. Larson		Middle 	Last 	15. MOTHER'S MAIDEN NAME First Carolyn		Middle 	Last 	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown — - -		16b. SOCIAL SECURITY NO. — - -		17. INFORMANT LeCompte Funeral Service records		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 7720		SUBDURAL HEMATOMA DUE TO, OR AS A CONSEQUENCE OF TENTORIAL TEAR						6 DAYS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. — - -								6 DAYS
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) 7600		bilateral pneumonia, massive						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING □ OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, (OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from 4-30 , 19 68 , to 5-7 , 19 68 , that (I) (we) last saw the deceased alive on 5-6 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE Donald R. McWilliams, M.D.		DEGREE	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 5-8-68		
22d. PHYSICIAN'S NAME (Type) Donald R. McWilliams, M.D.		22e. ADDRESS P.O. Box 248, East New Market, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE May 8, 1968		23c. NAME OF CEMETERY OR CREMATORIAL Dorchester Memorial Park		23d. LOCATION (City or Town) (County) (State) Cambridge, Maryland		
24. FUNERAL DIRECTOR LeCompte Funeral Service, Cambridge, Maryland		ADDRESS		25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE Charles Judge		
VR A15 (4) 30M REV. 1/68				MAY 13, 1968				

81-0923

ROUTE

ROUTE

111

BOOK OF

MOUNT

CLAY

3

BOOK OF LEAVES

CLAY

CLAY

CLAY

CLAY

CLAY

Fog hyacinth - 24 specimens

Subtropical

BOOK - selected

Second - selected

BOOKS - selected - Second - selected

Book - selected - Second - selected - Second - selected

CLAY

CLAY

CLAY

CLAY

CLAY - selected - Second - selected - Second - selected

CLAY - selected - Second - selected - Second - selected

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

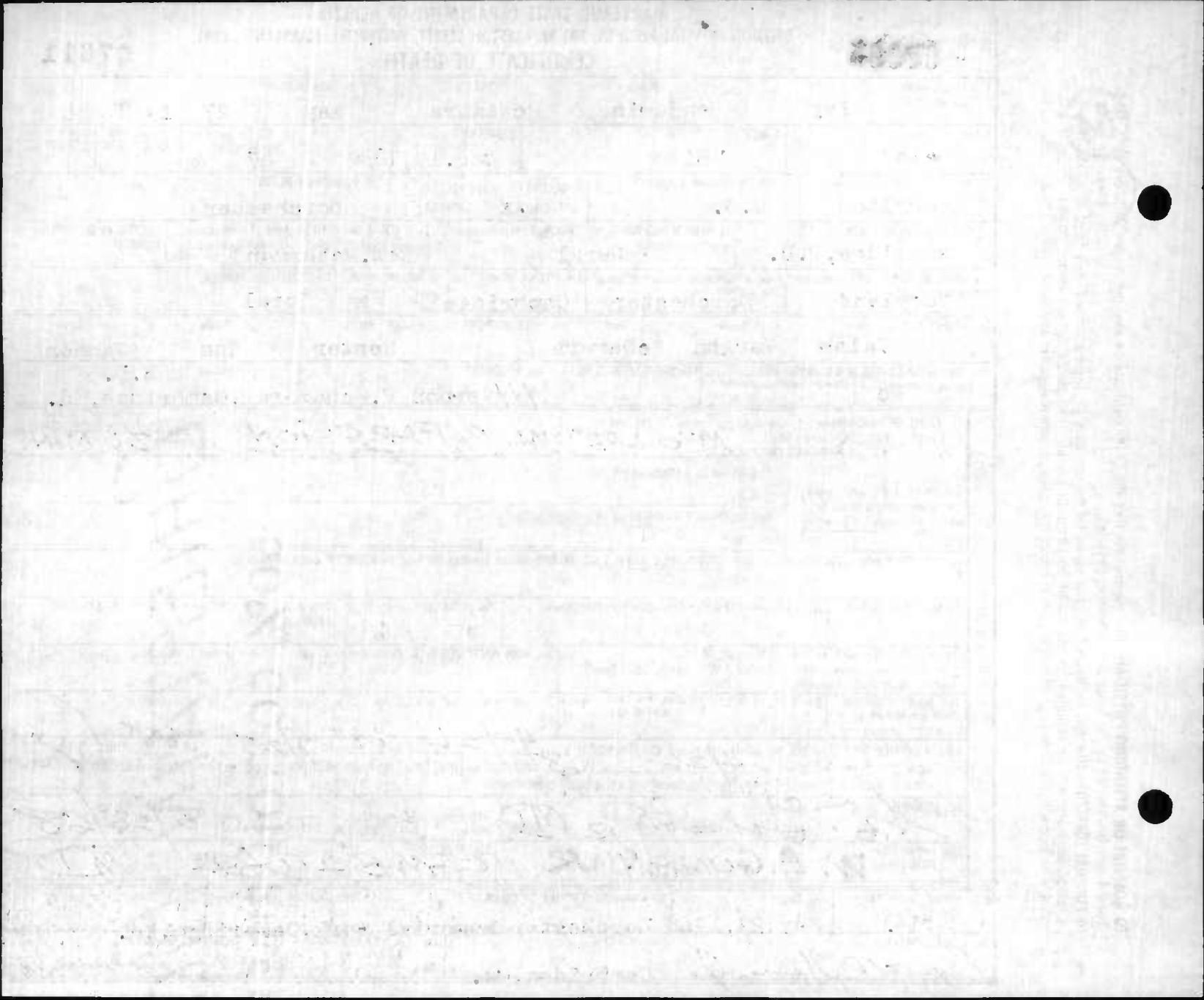
1. DECEASED-NAME (Type or print)			First	Middle	Lost	20. DATE OF DEATH Month	2b. HOUR Year
<i>Etha E. (Hastings) Livingston</i>						5 23	7:30 A.M.
3. SEX		4. RACE	S. DATE OF BIRTH		6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
Female		white	2-27-1881		87 YRS.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH	X Md.	
Maryland		U.S.A			Dorchester		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		
Cambridge		Eastern Shore State Hospital Housewife			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER		
Maryland		Wicomico	Salisbury	YES <input type="checkbox"/>	Route #1		
14. FATHER'S NAME		First	Middle	Lost	15. MOTHER'S MAIDEN NAME	First	Middle
		William	Hastings		Eiza	Hastings	Workman
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? <i>Unknown</i>		16b. SOCIAL SECURITY NO. <i>No</i>		17. M. INFORMANT Clyde G. Livingston, Address <i>1, Salisbury, Md.</i>	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
(Yes, no, or unknown) (If yes give war or dates of service)		217-36-0266A		EASTERN SHORE STATE HOSPITAL MED. RECORDS	2 yrs.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic Cardiovascular Disease with</i>							
DUE TO, OR AS A CONSEQUENCE OF <i>Left Ventricular Failure</i>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____							
DUE TO, OR AS A CONSEQUENCE OF (c) _____							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
4/22/1							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from <i>5/22/68</i> , 19_____, to <i>5/23/68</i> , 19_____, that (I) (we) lost saw the deceased alive on <i>5/22/68</i> , 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Samuel P. Wise MD</i>		DEGREE	ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED <i>5/23/68</i>	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS <i>Cambridge, Maryland</i>					
Dr. Samuel P. Wise							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>May 27, 1968</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Union Church Cemetery</i>		23d. LOCATION (City or Town) <i>Salisbury, Wicomico, Maryland</i>	(County)	(State)
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND		ADDRESS		25a. REC'D BY REGISTRAR <i>MAY 27 1968</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

PHOTOGRAPH

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)			First Ivy	Middle Benjamin	Last McNamara	2d. DATE OF DEATH Month May	2b. HOUR 4 P.M.	
3. SEX Male		4. RACE White	5. DATE OF BIRTH Dec. 19, 1880			6. AGE (In years last birthday) 87 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Dorchester			Md.
10. CITY OR TOWN OF DEATH Cambridge, R.D.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Rural			12. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Net. Waterman			12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Dorchester	13c. CITY OR TOWN Cambridge		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER Rural		
14. FATHER'S NAME Caleb Vaughn McNamara		15. MOTHER'S MAIDEN NAME Moster	First Ann	Middle	Last Cannon			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO.		17. INFORMANT Vernon F. McNamara, Cambridge, Md.			Address R.D. 3	
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</p> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYO CARDIAL MYFARCTION</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 MIN.</p> <p>4109 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b), last. (c)</p> <p>DUE TO, OR AS A CONSEQUENCE OF</p> <p>DUE TO, OR AS A CONSEQUENCE OF</p> <p>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)</p> <p>8201</p>								
19a. DATE OF OPERATION MEDICAL CERTIFICATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>4/26</u> , 19 <u>68</u> , to <u>5/27</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>4/26</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>W. E. GUNBY JR.</u>		22c. MEDICAL DEGREE ATTENDING PHYS.			22d. STAFF PHYS.	22e. ADDRESS <u>CABRIDGE MD</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE May 29, 1968	23c. NAME OF CEMETERY OR CREMATORIAL PARK Dorchester Memorial Park Cambridge, Md.			23d. LOCATION (City or Town) (County) (State)		
24. FUNERAL DIRECTOR Bennett R. Horne Jr.		ADDRESS Cambridge, Md.			25a. REC'D BY REGISTRAR DATE MAY 31 1968	25b. REGISTRAR'S SIGNATURE Charles Judge		



FOR STATE
HEALTH DEPT.

Any delay is
necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to
the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page
5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of
Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED NAME (Type or Print) JAMES HARVEY				First	Middle	Lost	20. DATE KNOWN <input checked="" type="checkbox"/> Month Day Year OF ESTI- DEATH MATED <input type="checkbox"/> MAY 10 1968	2b. HOUR 2:30
3. SEX MALE	4. RACE WHITE	S. DATE OF BIRTH 9/15/85	6. AGE (in years last birthday) 82 YRS.	IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS. DAYS 0	HOURS 0	MIN. 0	
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH DORCHESTER		
10. CITY OR TOWN OF DEATH RURAL CAMBRIDGE		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) EASTERN SHORE STATE HOSP.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) NONE		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13c. CITY OR TOWN TALBOT		13d. INSIDE CITY LIMITS? ST. MICHAELS YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
14. FATHER'S NAME First EUGENE MITCHELL				15. MOTHER'S MAIDEN NAME First JOSEPHINE PARSONS				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 212-56-1197T		17. INFORMANT HOSPITAL RECORDS		ADDRESS		
18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) 4109 <i>Burned while taking bath, R.I.</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause 4109 <i>coronary occlusion</i> DUE TO, OR AS A CONSEQUENCE OF (b)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o) 4201								
19a. MEDICAL CERTIFICATION DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. 6:30 P.M. 3/17 1968		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.) BURNED WHILE TAKING BATH.				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) HOSPITAL		21f. LOCATION Street or R.F.D. No. CAMBRIDGE, MD.		City or Town	County	State
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> PETER W. RIECKERT, M.D.								
ACTUAL SIGNATURE <i>Peter W. Rieckert, M.D.</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED 5-10-68		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 5/13/1968		23c. NAME OF CEMETERY OR CREMATORIAL OXFORD		23d. LOCATION (City or Town) OXFORD, MD.		
24. FUNERAL DIRECTOR Merle L. Neumannson		ADDRESS Kinston, Md.		25a. RECD BY REGISTRAR DATE MAY 15 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

30071



FOR STATE
HEALTH DEPT.

Item 18 film 401
D-13-68 mt MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
07007

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07013

1. DECEASED-NAME (Type or Print)			First MAGGIE	Middle ABBOTT	Lost MOORE	2a. DATE KNOWN OF ESTI- DEATH MATED	Month May	Day 12	Year 1968	2b. HOUR 2 A M
3. SEX Female	4. RACE White	S. DATE OF BIRTH Mar. 10, 1889	6. AGE (in years last birthday) 79 YRS.	IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS. DAYS 0	HOURS 0	MIN. 0	2c. DATE PRONOUNCED DEAD Month May Day 12 Year 1968		
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Dorchester		2d. HOUR 2, 15		
10. CITY OR TOWN OF DEATH Cambridge			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Cambridge Md. Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife			12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Dorchester		13c. CITY OR TOWN Cambridge	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 738 Race Street			
14. FATHER'S NAME First Charles			Middle ?	Lost Abbott	15. MOTHER'S MAIDEN NAME First Mary			Middle Jane	Lost Willey	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16b. SOCIAL SECURITY NO. 220-03-5742			17. INFORMANT LeCompte Funeral Service records			ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 485 X Pending autopsy Broncho Pneumonia										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days
Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o) 491 X										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										22b. DATE SIGNED 5/13/68
ACTUAL SIGNATURE <i>John Mace Jr.</i>			CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county) Robbins, Dor. Co., Md.	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE May 14, 1968		23c. NAME OF CEMETERY OR CREMATORIAL Sandy Island Cemetery			23d. LOCATION (City or Town) Robbins, Dor. Co., Md.			(County) (State)
24. FUNERAL DIRECTOR LeCompte Funeral Service, Cambridge, Maryland			ADDRESS			25a. REC'D BY REGISTRAR DATE MAY 27 1968			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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26088

S 28 MI VEN

27088

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25

26 27 28 29 30 31 32 33 34

red orange

220

brown

grey

yellow

black

yellow

grey and grey

yellow and yellow

grey

grey

grey

grey

grey

grey

old car painted later on stripped 2172-CC-30

28

V.V.

grey

old car stripped

yellow and grey 202-CC-30

greyish and brownish yellow later on stripped

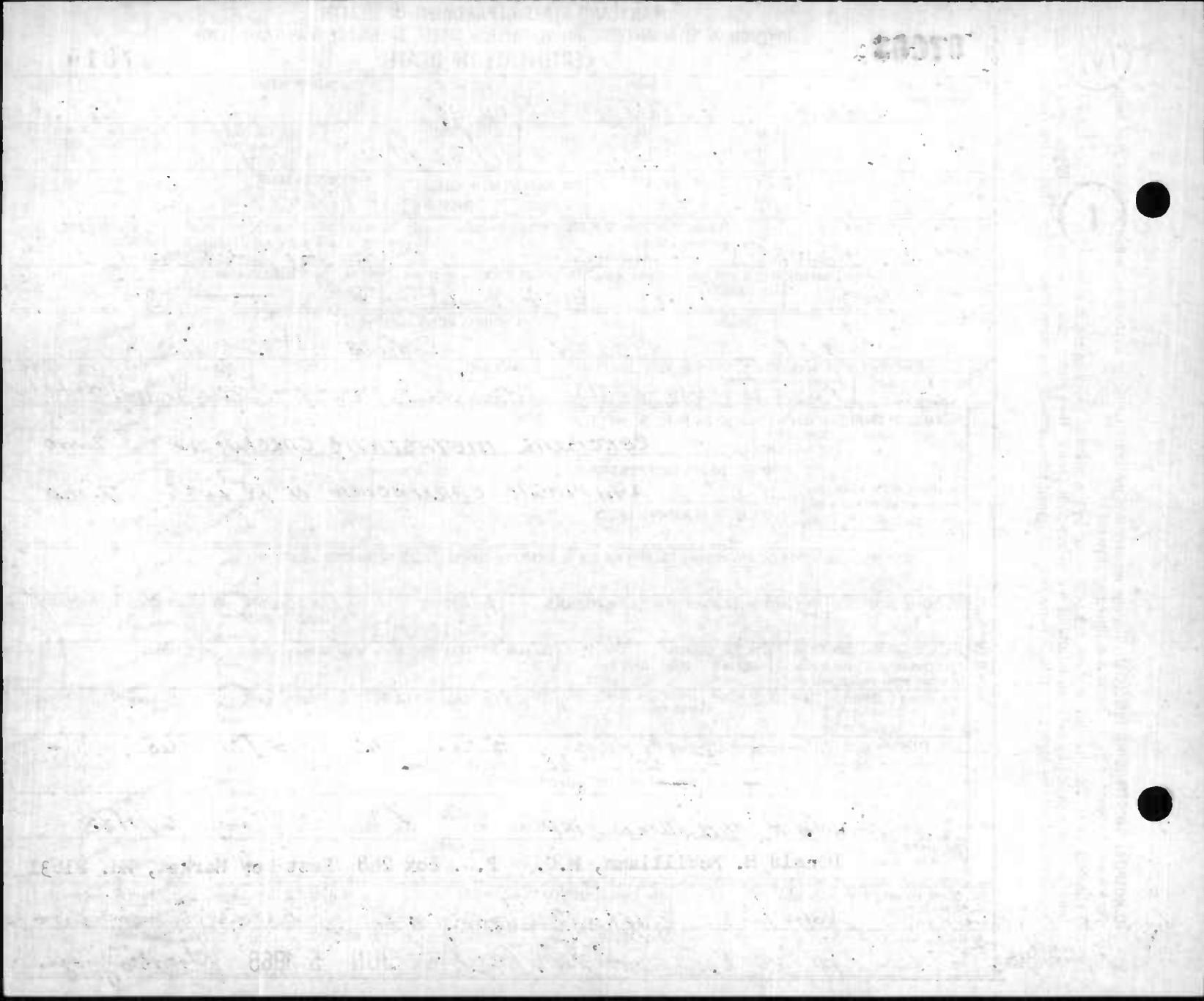
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR 68 8:30 A.M.
<i>John Francis Moxey</i>						Month 5 Day 31 Year 68	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday) 54 yrs.	
<i>Male</i>		<i>white</i>		<i>11/30/1913</i>		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State, or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED WIDOWED		9. COUNTY OF DEATH	
<i>Md.</i>		<i>A.S.A.</i>		<input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED		<i>Dorchester</i>	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Owned Auto Clean, 1/1/68</i>		
<i>East New Market</i>							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<i>Md</i>		<i>Dor</i>		<i>East New Market</i>			
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME	First	Middle
<i>Frank</i>				<i>Moxey</i>	<i>Emma</i>	<i>Havlick</i>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address	
<i>Yes</i>		<i>W.W.II</i>		<i>214-07-8135</i>		<i>Mrs John F. Moxey, East New Market</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>1621</i> DUE TO, OR AS A CONSEQUENCE OF <i>CEREBRAL METASTATIC CARCINOMA</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 mo</i>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF <i>ANAPLASTIC CARCINOMA OF RT. LUNG</i> <i>2 mo.</i>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
163X							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town	County State
22a. I certify that (I) (this hospital) attended the deceased from <i>3-12, 1968</i> , to <i>5/31, 1968</i> , that (I) (we) last saw the deceased alive on <i>5-30 1968</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Donald R. McWilliams, M.D.</i>		22c. DATE SIGNED <i>6/1/68</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR		STAFF PHYS. <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS					
<i>Donald R. McWilliams, M.D.</i>		<i>P.O. Box 248 East New Market, Md. 21631</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>6/3/68</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Overlook of Brook Forest</i>		23d. LOCATION (City or Town) (County) (State) <i>Secretary Dor M</i>	
24. FUNERAL DIRECTOR <i>United Mortuary East New Market</i>		ADDRESS		25a. REC'D BY REGISTRAR DATE JUN 5 1968		25b. REGISTRAR'S SIGNATURE <i>Charles J. Moore</i>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 5 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)			First CLYDE	Middle O.	Last MURPHY	2a. DATE OF DEATH Month May Doy 9 , Year 1968	2b. HOUR M
3. SEX Male		4. RACE White	5. DATE OF BIRTH Oct. 15, 1897		6. AGE (In years last birthday) 70 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED WIDOWED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH Dorchester		
10. CITY OR TOWN OF DEATH Cambridge		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Cambridge Md. Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Caretaker		12b. KIND OF BUSINESS OR INDUSTRY Farms
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Dorchester		13c. CITY OR TOWN Bishops Head	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER None	
14. FATHER'S NAME First Winfield		Middle Murphy	Last	15. MOTHER'S MAIDEN NAME First Glennie		Middle Murphy	Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. unk		17. INFORMANT LeCompte Funeral Service records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) Part I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure 1532 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Secondary Cancerous disease - Colon DUE TO, OR AS A CONSEQUENCE OF (c) 3 yrs							
Part 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 1532							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from Oct , 19 65 , to 5-9 , 19 68 , that (I) (we) last saw the deceased alive on 5-9 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Wilbur N. Baumann</i>		22c. DEGREE MD	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 5-10-68	
22d. PHYSICIAN'S NAME (Type) Wilbur N. Baumann, MD		22e. ADDRESS Aurora Street, Cambridge, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE May 12, 1968	23c. NAME OF CEMETERY OR CREMATORIAL Dorchester Memorial Park		23d. LOCATION (City or Town) Cambridge, Maryland	(County)	(State)
24. FUNERAL DIRECTOR LeCompte Funeral Service, Cambridge, Maryland		ADDRESS		25a. REC'D BY REGISTRAR MAY 15	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	DATE 1968	

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper, pages 1 and 2, from the back of this certificate, page 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. DECEASED-NAME (Type or print)			First GEORGE	Middle MILTON	Last MURPHY	2a. DATE OF DEATH Month May	Day 30	Year 1968	2b. HOUR M	
3. SEX Male		4. RACE White	5. DATE OF BIRTH December 1, 1895			6. AGE (In years last birthday) 72		IF UNDER 1 YEAR MONTHS YRS.		
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Dorchester			Md.	
10. CITY OR TOWN OF DEATH Cambridge		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Cambridge Md. Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Waterman-Retired			12b. KIND OF BUSINESS OR INDUSTRY Seafood		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Dorchester		13c. CITY OR TOWN Wingate		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER None		
14. FATHER'S NAME First Winfield			Middle P.	Last Murphy	15. MOTHER'S MAIDEN NAME First Glennie			Middle ?	Last Murphy	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes			16b. SOCIAL SECURITY NO. unk		17. INFORMANT LeCompte Funeral Service records			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 DAYS
4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). (b) stating the underlying cause lost. (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201 DIABETES MELLITUS										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING □ OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At Home, Farm, Street, Factory, Office Building, Etc.)			21f. LOCATION Street or R.F.D. No.		City or Town		County	State
22a. I certify that (I) (this hospital) attended the deceased from 27 MAY 1968 , to 30 MAY 1968 , that (I) (we) last saw the deceased alive on 29 MAY 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE W.E. Guiby Jr. MD		DEGREE MD	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 31 May 68				
22d. PHYSICIAN'S NAME (Type) W.E. Guiby Jr.		22e. ADDRESS CAMBRIDGE MD.								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Jun 1, 1968		23c. NAME OF CEMETERY OR CREMATORIAL Dorchester Memorial Park			23d. LOCATION (City or Town) Cambridge, Maryland		(County) (State)	
24. FUNERAL DIRECTOR LeCompte Funeral Service, Cambridge, Maryland		ADDRESS			25a. REC'D BY REGISTRAR DATE JUN 3 1968			25b. REGISTRAR'S SIGNATURE Charles Judge		

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10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours of death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 Item #7b Film #G400 575768 ph										07017	
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)		First		Middle		Last		2. DATE OF DEATH		2b. HOUR	
Alexander						Reid		5 Month 4 Day 68 Year		55 10a.m.	
3. SEX		4. RACE		S. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Male		Negro		03-17-85		83 YRS.		MONTHS		DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		9. COUNTY OF DEATH		Md.			
Jamaica, West Indies		U.S.A.		<input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED		Doechester					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Cambridge		Eastern Shore State Hosp				minister					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER					
Maryland		Wicomico / Westover		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		none					
14. FATHER'S NAME First		Middle		Last		15. MOTHER'S MAIDEN NAME First		Middle		Last	
Thomas				Reid		Inie Reid					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
no		219-34-3803A		Eastern Shore State Hosp,		Cambridge Maryland		1 WK			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA 250.9 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) RENAL FAILURE DUE TO, OR AS A CONSEQUENCE OF (c) DIABETIS MELLITIS + KIMMESTEL-WILSON DISEASE 5+YRS 1 MOS.											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 260x GENERALIZED ARTERIOSCLEROSIS.											
19a. MEDICAL CERTIFICATION DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from 3-29 1968, to 5-4 1968, that (I) (we) lost saw the deceased alive on 5-4 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		22c. DEGREE		ATTENDING PHYS.		MED. DIRECTOR		STAFF PHYS.		22d. DATE SIGNED	
Sean M Killoran		MD		<input checked="" type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		May 4, 1968	
22e. PHYSICIAN'S NAME (Type)		NAME		ADDRESS		23d. LOCATION (City or Town)		(County)		(State)	
SEAN M. KILLORAN MD		7415		BLAIR RD WASHINGTON DC		Salisbury		Somerset		Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS		23d. LOCATION (City or Town)		(County)		(State)	
Burial		5/8/68		Green Acres		Salisbury		Somerset		Md.	
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Clinton J. Stewart / Frank		Salisbury Md.		MAY 7 1968		Charles Judge					
VR A15 (4) 30M REV. 1/68											

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17018

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1and2 with the State Department at Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED NAME (Type or Print)	First	Middle	Last	2a. DATE KNOWN OF ESTI- DEATH MATED	Month	Day	Year	2b. HOUR
	Claude	Swanson	Shackleford	<input type="checkbox"/> 5/4	1968	168	? P.M.	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (in years last birthday)	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS DAYS	HOURS	MIN.	2d. HOUR
Male	White	2/12/1907	61 YRS					1P M
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8.	MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. COUNTY OF DEATH				
Virginia	U.S.			Dorchester				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY					
Cambridge	406 High St.	Custodian	Church					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER					
Md.	Dorchester	Cambridge	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 406 High St.					
14. FATHER'S NAME	First	Middle	Last	15. MOTHER'S MAIDEN NAME	First	Middle	Last	
	Nathaniel			Julia			Brooks	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
No		Ray Shackleford	534 S. Ann St. Balto.	Few mins.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure								
4270 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o) 4341								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY?	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town	County	State
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <i>John Mace Jr.</i>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED 5/8/68		
EXAMINER'S NAME (Type) John Mace Jr. M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county) Cambridge, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 5/7/68	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Greenlawn Cemetery Cambridge Md.		23d. LOCATION (City or Town) (County) (State) Cambridge Dorchester Md.				
24. FUNERAL DIRECTOR <i>Kenneth R. Thomas Jr.</i>	ADDRESS Cambridge Md.	25a. RECD BY REGISTRAR DATE MAY 15 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

I 1
 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Ages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)		First HELEN	Middle	Last TILGHMAN	2a. DATE OF DEATH Month MAY Day 18 , Year 1968	2b. HOUR 1:35 PM
3. SEX FEMALE	4. RACE NEGROID	5. S. DATE OF BIRTH AUGUST 9, 1905		6. AGE (in years lost birthday) 62 YRS.	IF UNDER 1 YEAR MONTHS 0 DAYS 0	IF UNDER 24 HRS. HOURS 0 MIN. 0
7a. BIRTHPLACE (State or foreign country) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH DORCHESTER			
10. CITY OR TOWN OF DEATH CAMBRIDGE	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) CAMBRIDGE MD. HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) LABORER		12b. KIND OF BUSINESS OR INDUSTRY DOMESTIC	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND	13b. COUNTY DORCHESTER	13c. CITY OR TOWN CAMBRIDGE	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER BAYLY ROAD		
14. FATHER'S NAME First UNKNOWN	Middle	Last	15. MOTHER'S MAIDEN NAME First IDA	Middle MAE	Last COOPER	Address CAMBRIDGE, MD.
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO	16b. SOCIAL SECURITY NO.	17. INFORMANT ONDERLYNE T. STAFFORD	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MINUTES			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o) 4201 OBESEITY						
19a. DATE OF OPERATION 4201	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from 11-28 , 19 67 , to 5-18 , 19 68 , that (I) (we) last saw the deceased alive on 5-17 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <i>James F. McCarter, M.D.</i>	DEGREE	ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 5-24-68			
22d. PHYSICIAN'S NAME (Type) JAMES F. McCARTER, M.D.	22e. ADDRESS 704 LOCUST STREET CAMBRIDGE, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 5/22/68	23c. NAME OF CEMETERY OR CREMATORIAL BETHEL	23d. LOCATION (City or Town) CAMBRIDGE	(County) DOR.	(State) MD.	
24. FUNERAL DIRECTOR <i>Frederick C. St. Clair</i>	ADDRESS CAMBRIDGE, MD.	25a. REC'D BY REGISTRAR MAY 29 1968	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)	First MEEKINS	Middle	Lost TRAVERS	2d. DATE OF DEATH Month MAY Day 8 , Year 1968	2b. HOUR 1:45 P.M.
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH 6/12/90	6. AGE (In years last birthday) 77 YRS.	IF UNDER 1 YEAR MONTHS 0 DAYS 0	IF UNDER 24 HRS. HOURS 0 MIN. 0
7a. BIRTHPLACE (State or foreign country) Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH DORCHESTER		
10. CITY OR TOWN OF DEATH RURAL CAMBRIDGE	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) EASTERN SHORE STATE HOSP.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) WATERMAN	12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.	13b. COUNTY DOR.	13c. CITY OR TOWN CAMBRIDGE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 403 CEDAR ST.	
14. FATHER'S NAME First MEEKINS TRAVERS	Middle	Lost	15. MOTHER'S MAIDEN NAME First SARAH RUARK	Middle	Lost
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 220-12-2404A	17. INFORMANT HOSPITAL RECORDS	Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4109					
Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause (b) DUE TO, OR AS A CONSEQUENCE OF lost. (c) DUE TO, OR AS A CONSEQUENCE OF					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
MEDICAL CERTIFICATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from 12/12 , 19 67 , to 5/8 , 19 68 , that (I) (we) last saw the deceased alive on 5/8 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE B.A.W. Weeks	DEGREE ATTENDING PHYS.	MED. DIRECTOR <input checked="" type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 5/8/68	
22d. PHYSICIAN'S NAME (Type) Beth U. Rieckert	22e. ADDRESS E-Vans Market Rd				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE May 10, 1968	23c. NAME OF CEMETERY OR CREMATORIAL Dorchester Memorial Park	23d. LOCATION (City or Town) (County) (State) Cambridge, Maryland		
24. FUNERAL DIRECTOR ANTHONY L. COMPTON, CAMBRIDGE, MD	ADDRESS Anthony L. Compton, Cambridge, MD	25a. REC'D BY REGISTRAR Charles Judge	25b. REGISTRAR'S SIGNATURE Charles Judge		
VR A15 (4) 30M REV. 1/68					

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bilingual section of the Bronx Museum of Art
Bronx, New York

FOR STATE
HEALTH DEPT

**MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

07021

1. DECEASED NAME (Type or Print)		First CHARLOTTE	Middle	Lost VRANA	2a. DATE KNOWN OF ESTI- DEATH MATED	Month May 27	Day 19	Year 68	2b. HOUR 11A													
3. SEX Female	4. RACE White	5. DATE OF BIRTH Dec. 17, 1889	6. AGE (In years last birthday) 78 yrs.	IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS DAYS 0	IF UNDER 24 HRS HOURS 0	IF UNDER 24 HRS MIN 0	2c. DATE PRONOUNCED DEAD Month 5	Day 27	Year 1968	2d. HOUR 11A											
7a. BIRTHPLACE (State or foreign country) New York		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED		9. COUNTY OF DEATH Dorchester																
10. CITY OR TOWN OF DEATH Cambridge		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Cambridge Md. Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home																
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Dorchester		13c. CITY OR TOWN East New Market		13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		13e. STREET AND NUMBER None														
14. FATHER'S NAME Charles	First	Middle	Last Nonks	15. MOTHER'S MAIDEN NAME Sarah		Middle	Last Bailey															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. Unk		17. INFORMANT LeCompte Funeral Service records		ADDRESS Instant																
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying cause</u> { (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____																						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201																						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____																		
22o. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>																						
ACTUAL SIGNATURE <i>John Mace Jr.</i>		EXAMINER'S NAME (Type) John Mace Jr. M.D.		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED 5/28/68												
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial													23b. DATE May 29, 1968		23c. NAME OF CEMETERY OR CREMATORIAL Dorchester Memorial Park		23d. LOCATION (City or Town) Cambridge, Maryland		(County) Cambridge		(State) Maryland	
24. FUNERAL DIRECTOR LeCompte Funeral Service, Cambridge, Maryland		ADDRESS LeCompte Funeral Service, Cambridge, Maryland		25o. REC'D. BY REGISTRAR DATE SUN 3 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>																

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. DECEASED NAME (Type or print)		First Grace	Middle	Last Webster	2d. DATE OF DEATH Month 5 Day 10 Year 68	2b. HOUR M		
3. SEX F	4. RACE White	5. DATE OF BIRTH 4-29-87		6. AGE (In years last birthday) 81 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Md	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH Dorchester		<i>Md.</i>			
10. CITY OR TOWN OF DEATH Cambridge	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Cambridge Hosp.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired		12b. KIND OF BUSINESS OR INDUSTRY ---				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) Md	13b. COUNTY Somerset	13c. CITY OR TOWN Deal Island	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER Main Rd				
14. FATHER'S NAME First William	Middle Webster	Last	15. MOTHER'S MAIDEN NAME First Ursula	Middle	Last Whayland			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16b. SOCIAL SECURITY NO. Unknown	17. INFORMANT Mrs. Margaret Ward	410 <i>Add.</i> Athol St		Balto MD 29			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage with Hemiplegia (2 weeks) DUE TO OR AS A CONSEQUENCE OF (b) Left Atherosclerotic Heart Disease DUE TO OR AS A CONSEQUENCE OF (c) Hypertension						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 331X								
MEDICAL CERTIFICATION		19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> <input type="checkbox"/> of work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State		
22a. I certify that (I) (this hospital) attended the deceased from 5-6, 1968, to 5-10, 1968, that (I) (we) last saw the deceased alive on 5-10- 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <i>Carlos F. Barros</i>		MD DEGREE	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 5-10-68		
22d. PHYSICIAN'S NAME (Type) Carlos F. Barros		MD	22e. ADDRESS S. Main St. Hurlock Md					
23a. BURIAL, CREMATION, Burial <i>(Specify)</i>	23b. DATE 5-12-68	23c. NAME OF CEMETERY OR CREMATORIAL St John's Cemetery		23d. LOCATION (City or Town) Deal Island Som	(County) MD	(State)		
24. FUNERAL DIRECTOR <i>Lerry Webster</i>	ADDRESS Princess Anne MD	25a. REC'D BY REGISTRAR MAY 17 1968		25b. REGISTRAR'S SIGNATURE <i>Judge</i>				
VR A15 (4) 30M REV. 1/68								

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #13c & e Film#G400 5/20/68 Ph

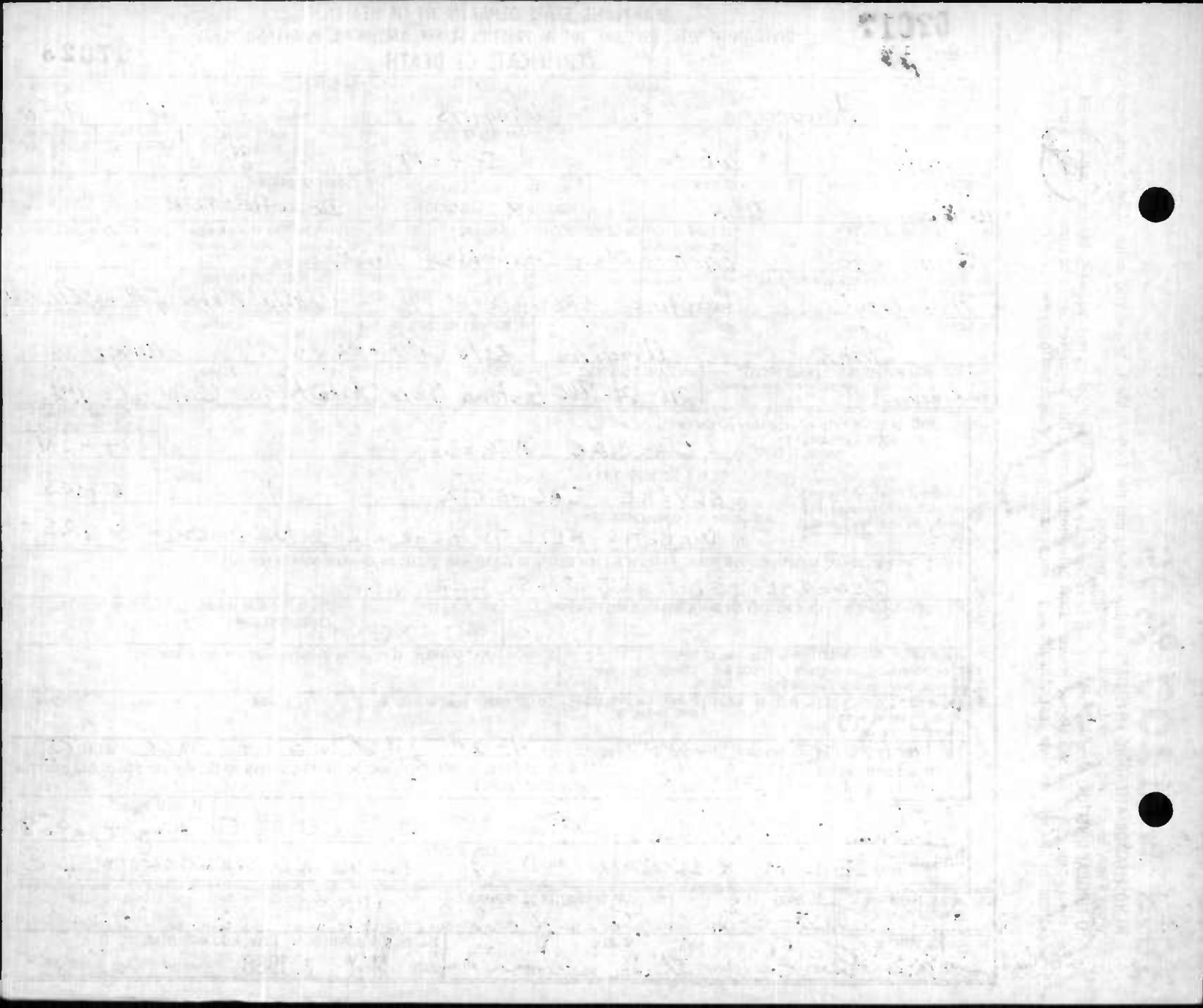
CERTIFICATE OF DEATH

07023

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper from pages 1 and 2, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or print)	First <i>Howard</i>	Middle <i>F.</i>	Last <i>Wiggins</i>	2d. DATE OF DEATH 5 Month 4 Day 68 Year	2b. HOUR 9:15 AM
3. SEX <i>male</i>	4. RACE <i>white</i>	S. DATE OF BIRTH <i>5-4-79</i>	6. AGE (In years lost birthday <i>89</i> YRS.)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <i>unknown</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Dorchester</i>	Md.	
10. CITY OR TOWN OF DEATH <i>Cambridge</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital and street address) <i>Eastern Shore State Hosp.</i>	12d. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>unknown</i>	12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>	13c. CITY OR TOWN <i>Henderson</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <i>Collins Wharf Rd/Route 50/</i>		
14. FATHER'S NAME First <i>John</i>	Middle <i>Wiggins</i>	15. MOTHER'S MAIDEN NAME First <i>Kate Comegys</i>	Middle <i>Wiggins</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>unknown</i>	16b. SOCIAL SECURITY NO. <i>216-54-8866</i>	17. INFORMANT Address <i>Eastern Shore State Hosp. Cambridge, MD.</i>	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>4 MIN</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CARDIAC ARREST</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <i>SEVERE CACHEXIA</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>DIABETIS MELLITIS + CHRONIC RENAL DISEASE</i> Approximate Interval Between Onset and Death <i>6 MOS</i> <i>2 YRS+</i>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>260x GENERALIZED ARTERIOSCLEROSIS.</i>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	21e. PLACE OF INJURY (At Home, Farm, Street, Factory, Office Building, Etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) <input type="checkbox"/> (this hospital) attended the deceased from <i>4-29 1968</i> , to <i>5-4 1968</i> , that (I) <input checked="" type="checkbox"/> (we) last saw the deceased alive on <i>5-4 1968</i> , and that in (my) <input type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> (we) <input type="checkbox"/> (did) <input type="checkbox"/> (did not) view the body after death.					
22b. SIGNATURE <i>Sean M Killoran MD</i>	22c. DATE SIGNED <i>May 4, 1968</i>				
22d. PHYSICIAN'S NAME (Type) <i>SEAN M. KILLORAN MD</i>	22e. ADDRESS <i>7415 BLAIR RD, WASHINGTON, D.C.</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>5-8-68</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Greensboro</i>	23d. LOCATION (City or Town) <i>Greensboro</i>	(County) <i>Me.</i>	(State)
24. FUNERAL DIRECTOR <i>John E Bowles</i>	ADDRESS <i>Greensboro, MD</i>	25a. REC'D BY REGISTRAR DATE <i>Charles Judge</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



FOR STATE
HEALTH DEPT.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PW3, Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED NAME (Type or Print)		First	Middle	Last	2a. DATE KNOWN OF ESTI. DEATH MADE	Month	Day	Year	2b. HOUR
JOHN		PAUL	WOITHON		<input checked="" type="checkbox"/>				19 68 7 P.M.
3. SEX	4. RACE	S. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD Month Day Year			2d. HOUR
MALE	WHITE	10-18-83	84 YRS			MAY 7 19 68			7:30 PM
7a. BIRTHPLACE (State or foreign country) GERMANY		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH DORCHESTER			
10. CITY OR TOWN OF DEATH CAMBRIDGE		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) EASTERN SHORE STATE HOSP.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) WATCHMAN			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY QUEEN ANNE'S		13c. CITY OR TOWN CHESTER		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
14. FATHER'S NAME - UNKNOWN		Middle	Last	15. MOTHER'S MAIDEN NAME - UNKNOWN		First	Middle	Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 218-34-3191		17. INFORMANT RECORDS OF THE EASTERN SHORE STATE HOSPITAL		ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) Jermaine Amersonia APPROXIMATE INTERVAL DUE TO, OR AS A CONSEQUENCE OF 2 days									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) Prostator neck n. femur 33 days									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION 4/10/68		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		19c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.) Pushed by another patient		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 4/4/68		21c. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Hospital		21f. LOCATION Street or R.F.D. No. Cambridge, Md.			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. CITY OR TOWN Cambridge, Md.		21f. COUNTY Queen Anne's Co., Md.		21g. STATE Md.			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE John Mace		M.D.		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED 5/8/68			
EXAMINER'S NAME (Type) JOHN MACE M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county) 401 GLENBURN AVE., CAMB., MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE May 11, 1968		23c. NAME OF CEMETERY OR CREMATORIAL Chesterfield Cemetery		23d. LOCATION (City or Town) Chesterville Queen Anne's Co., Md.		(County) Queen Anne's Co., Md.	
24. FUNERAL DIRECTOR James H. Burton, Jr. Burton Bros. Chesterville, Md.		ADDRESS		25a. REC'D BY REGISTRAR DATE May 13 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 which should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. DECEASED-NAME (Type or print)		First Emma	Middle Wilson	Lost Wright	2d. DATE OF DEATH Month May Day 25 Year 1968	2b. HOUR P 3:30M
3. SEX Female		4. RACE White		S. DATE OF BIRTH Sept. 10, 1885	6. AGE (In years last birthday) 82 YRS.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Dorchester	
10. CITY OR TOWN OF DEATH Cambridge		11. NAME OF HOSPITAL OR INSTITUTION giving street address Hospital Cambridge-Maryland		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Travers & Willis Sts.
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Dorchester		13c. CITY OR TOWN Cambridge	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER Travers & Willis Sts.
14. FATHER'S NAME First James		Middle A.	Lost Wilson	15. MOTHER'S MAIDEN NAME First Emma	Middle Elliott	Lost Elliot
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. 216-12-1718		17. INFORMANT Mrs. Donald E. Matthews, Cambridge, Md.	Address APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 mos	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1519		DUE TO, OR AS A CONSEQUENCE OF Carcinomatosis				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 1519		DUE TO, OR AS A CONSEQUENCE OF Carcinoma Stomach				
19a. MEDICAL CERTIFICATION DATE OF OPERATION 151X		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from Nov 1967 , to May 25, 1968 , that (I) (we) last saw the deceased alive on May 25, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Dr. Baumann, MD		22c. DATE SIGNED 5-27-68				
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE May 28, 1968	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Christ Churchyard		23d. LOCATION (City or Town) Cambridge, Md.	(County) (State)
24. FUNERAL DIRECTOR Kenneth R. Thomas		ADDRESS Cambridge, Md.		25a. REC'D BY REGISTRAR May 31 1968	25b. REGISTRAR'S SIGNATURE 124	

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First Raymond	Middle Well	Last Wright	2a. DATE OF DEATH Month May	Day 11	Year 1968	2b. HOUR 5A M	
3. SEX Male	4. RACE White			5. DATE OF BIRTH 11/21/1888	6. AGE (In years last birthday) 79	YEARS	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS. DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH Dorchester				
10. CITY OR TOWN OF DEATH Cambridge		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Cambridge-Md. Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Painter		12b. KIND OF BUSINESS OR INDUSTRY House		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.	13b. COUNTY Dorchester	13c. CITY OR TOWN Cambridge		13d. INSIDE CITY LIMITS? YES	13e. STREET AND NUMBER 310 West End Ave.				
14. FATHER'S NAME Henry Martin Wright	First	Middle	Last	15. MOTHER'S MAIDEN NAME Bertha	Middle	Last Lyle			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO. (If yes give war or dates of service)	17. INFORMANT Mrs. Orville Willis		Address Cambridge Md.					
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</p> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF DESCENDING COLON E METASTASIS 1532 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)</p> <p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 Mo.</p>									
<p>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)</p> <p>1532 ARTERIOSCLEROTIC HT. DISEASE</p>									
19a. DATE OF OPERATION 5/3/68	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED CARCINOMA	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town		County	State			
<p>22a. I certify that (I) (this hospital) attended the deceased from April 17, 1968, to May 11, 1968, that (I) (we) last saw the deceased alive on May 10, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.</p>									
22b. SIGNATURE Alfred R. Maryanov	DEGREE ATTENDING PHYS	22c. DATE SIGNED 5/11/68		<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	<input type="checkbox"/>			
22d. PHYSICIAN'S NAME (Type) Alfred R. Maryanov, M.D.	22e. ADDRESS 610 Race St., Cambridge, Md. 21613								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 5/14/68	23c. NAME OF CEMETERY OR CREMATORIAL Christ Churchyard	23d. LOCATION (City or Town) Cambridge Dorchester Md.		(County) Dorchester		(State) Md.		
24. FUNERAL DIRECTOR Kenneth L. Thomas Jr.	ADDRESS Cambridge Md.	25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE Charles Judge					

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